

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041512

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10025

STATE FILE NUMBER

FILED OCT 17 1963

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **St. Louis**

Length of stay in 1b
1 Day

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **Jewish Hospital**

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY **St. Louis**

c. CITY OR TOWN **Pagedale**

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
1456 Ferguson Ave.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First **Mabel**

Middle **L.**

Last **Gunn**

4. DATE OF DEATH

Month **Oct.**

Day **9,**

Year **1963**

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

11-18-96

9. AGE (last birthday)

66

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (City and state or country)

Litchfield, Ill.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Henry Willems

13b. MOTHER'S MAIDEN NAME

Mary Louise (Unknown)

14. NAME OF HUSBAND OR WIFE

Joseph A. Gunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

17. INFORMANT

Address

Joseph A. Gunn, 1456 Ferguson Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH

Weeks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Arteriosclerotic heart disease

years

DUE TO (c)

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **1961** to **10/8/63** and last saw her alive on **10/8/63**
Death occurred at **6:25 AM 10/9/63** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Robert S. Loral, M.D.

22b. ADDRESS

2428 Woodson

22c. DATE SIGNED

10/9/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

removal (rail) 10-11-63

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

Appleton City

Mo.

24. FUNERAL DIRECTOR

ADDRESS

Drehmann-Harral, 1905 Union Blvd.

25. DATE RECD. BY LOCAL REG.

OCT 9 1963

26. REGISTRAR'S SIGNATURE

Robert Smith, M.D.

Dr. Robert Karsch
Arthritis Clinic-Barnes Hosp.
Clinical Bldg. 5th Floor
2 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert P. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.